OBSERVATIONS

ON A

PUBLIC HEALTH BILL

FOR

IRELAND,

PREPARED FOR THE

Irish Poor-law Medical Officers' Association

BY THE HON. SEC.,

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ETC., ETC.

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1, Harrington-terrace,
Dublin, *March*, 1874.

My Dear Sir,

The session of Parliament has now commenced, and, as was anticipated, the subjects of Local Taxation, Union Rating, and Sanitary Reform will furnish material for grave consideration during the present year. These questions will, of necessity, be dealt with very slowly and very carefully, in order that legislation resulting from their consideration may be comprehensive; and now is the time for careful work in matters of such great public importance.

There can be no doubt but that the discussions which will arise in the course of legislation on these subjects will affect the interests of the medical profession more or less, especially that section of the profession which is connected with the Poor-law Medical Service. Opportunities will also arise for bringing certain grievances which affect the profession before the legislature, and occasions will present themselves for redressing these grievances, and preventing further injustice being done to the profession from want of knowledge of the subject.

The cause of the Civil Servants, with whom we wish to associate ourselves, will also be advocated during the present session, and a fitting occasion will then be afforded for pressing forward our views on this subject.

As the suggestions hitherto made as to the method by which the Poor-law Medical Service might be joined to the Civil Service have been somewhat vague, I think it is advisable to lay before you the following statement as to how it might be effected, so that the whole of the salaries of Poor-law Medical Officers should be paid by the State, instead of the half only, as at present.

According to the last report of the Local Government Board of Ireland, the salaries of the Poor-law Medical Officers amounted in round numbers to £100,000, the cost of medicines and medical appliances to £33,000—total, £133,000; half of this, or £66,000, was paid by Government. Now the cost of medicines and medical appliances might, with justness, be defrayed out of the Poor Rates, as is the rent of dispensaries, books, forms, stationery, printing, fuel, and attendance, &c.; by this method £33,000 a year, now devoted to the purchase of medicines and medical appliances, would be applicable towards the payment of the salaries of the Medical Officers, by which means the increase in the Parliamentary grant would be but about £33,000 per annum, and the decrease in the Poor Rates would be, in round numbers, to a similar extent. This would have a beneficial effect on the ratepayers, as may be explained by the fact that in the county Donegal, where the valuation is 12s. per acre, the cost of medical relief is 3d. in the pound, and in Belfast, where the valuation is £12 per acre, the cost of medical relief is but $\frac{1}{4}$d. in the pound, showing how unevenly the cost of medical relief presses upon the rates at present; whilst sickness being a national calamity, the cost of its relief ought to be borne by the nation at large. Having thus endeavoured to explain the financial question connected with the consolidation of the Poor-law Medical with the Civil Service, we will pass on to the other points involved in the matter. As to the entrance into the Poor-law Medical service: the manner in which these appointments are made at present cannot be looked upon with satisfaction, and it may be asserted with safety that the qualifications now required for a Poor-law Medical Officer in Ireland are of a politico-religious rather than of a professional character, and examples are not only numerous but notorious where the best qualified men have been rejected, whilst those possessing inferior qualifications have been selected.

The apparent remedy for this is admission by competitive examination, as in the Civil Service. The number of Poor-law Medical Officers in Ireland is about 1,000, or about the same number as there are in the army; the annual number of vacancies is somewhat greater than in the army, being, on an average, 70 per annum. Two examinations might be held each year to fill up, say, thirty-five vacancies at each examination. The successful candidates might have the choice

of places in the order of merit of answering at the examination. This system would afford a fair guarantee to the public that well qualified men would be appointed, a matter of great importance in Ireland, where, with the exception of a few large towns, all the medical attendance of the community is in the hands of the Poor-law Medical Officers.

A system of promotion and increase of salary with length of service, as in the Civil Service, would furnish a valuable incentive for the zealous performance of duty. And certain superannuation, as in the Civil Service, would enable worn-out Officers to retire from duties which they are physically unable to perform, instead of, as at present is often times the case, their being allowed to continue in office long after it has ceased to be conducive to the public interest that they should do so, merely from charitable motives.

With regard to some of the principal grievances which affect the medical profession in Ireland, we may enumerate, first, the absence of any provision for the payment of medical witnesses in this country, whilst in England a scale of fees, as £1 1s. a day if resident in the town in which the cause is tried, and if resident at a distance from the place of trial, inclusive of all except travelling expenses, £2 2s. to £3 3s., travelling expenses not to exceed 1s. per mile one way.

As to those grievances affecting Poor-law Medical Officers in particular, we may instance the fact that, immediately after the passing of the Medical Act of 1858, the double qualification was required of all future Medical Officers, without any pecuniary compensation for the increased labour and expense incurred in obtaining their degrees. Upon that occasion it was found to be difficult to obtain men with high class double qualifications to hold the office at the salaries given; and the licence of the Dublin Apothecaries' Company was permitted to take the place of a medical qualification—a circumstance that did not have the effect of raising the standard of qualifications to the extent that had been intended. The State is now, through the Medical Council, about to insist upon a uniform high standard of qualification for the medical practitioners holding appointments in the public services. Already a "Conjoint Examination and Uniform Standard of Education Scheme" has been elaborated for the various divisions of the United Kingdom, and, as this becomes law, it will be necessary to see that adequate increase of remuneration will accompany increased requirements. Since the introduction of the Medical Charities Act, in 1851, there has been no increase of salary in the service commensurate with the increase in the cost of living, such as has taken place in all other branches of the public service.

In the case of Vaccination, in Ireland 1s. is the maximum for each successful case of vaccination, and even that is not payable in every case. In England the minimum fee is 1s. 6d., and at present the fee for each successful case of vaccination is 3s., according to the last report, in addition to gratuities, amounting in the total to a sum little short of the total amount paid for vaccination fees in Ireland.

With regard to the Registrations of Births and Deaths, we are also placed at a disadvantage when compared with the Registrars in England; the latter, in addition to receiving larger fees for registration and certificates, have facilities afforded them for more perfect registration than exists in Ireland, inasmuch as no burial can take place without the knowledge of the Registrar by means of certificates forwarded by the person burying or performing any religious service for the burial of such dead body.

Special remuneration is also given in England to the Poor-law Medical Officers (for certain operations and services), which does not exist here—for instance, for ordinary midwifery cases, a sum not less than 10s., nor more than 20s., as the guardians may agree with such officer. In special cases of difficulty, the Medical Officer is entitled to a fee of £2. For the treatment of compound fractures or dislocations, amputations, and the operation for strangulated hernia, the fee is £5. For simple fractures and dislocations of the thigh or leg, the fee is £3. For dislocations or fractures of the arm, the fee is £1.

Perhaps the most flagrant grievance that has been imposed upon Irish Poor-law Medical Officers is the Dangerous Lunatic Act, which enacts that any Dispensary Medical Officer may be called upon to examine and certify for any person suspected of being a dangerous lunatic "*without fee or reward*"—provision is made for payment for such cases in the other divisions of the United Kingdom. It is true that this grievance does not affect the great majority of the Dispensary Medical Officers of Ireland, but about 1,000 alleged dangerous lunatics are annually examined by these gentlemen, and nearly one-third of that number come under the supervision of the Medical Officers of one dispensary, namely, the No. 3 North Dublin City District, in which the Dublin Metropolitan Police-courts are situated.

It may be laid down as an axiom, that all these disabilities affecting the

Medical Profession in Ireland, have arisen to a great extent from apathy, the all-engrossing nature of the duties connected with the Medical service, and the absence of an association especially devoted to the consideration of the wants of the Poor-law Medical Service.

A most important era has now arrived for this service, and that is the introduction of a Public Health Bill for Ireland, and if this measure is not carefully watched in its progress through Parliament, it is possible that we may find ourselves subjected to a greater grievance that any under which we have hitherto laboured.

In 1872, the Public Health Act, England, became law, and England and Wales were divided into Urban and Rural districts for sanitary purposes. The number of these districts amounts to about 2,000, and the number of Medical Officers of Health, appointed up to the present, is about 1,000; their salaries as Medical Officers of Health vary from under 40 up to £400 a-year and up to £800, and even above that sum, owing to the peculiarities of the English Poor-law Medical system, but in round numbers they may be estimated in the aggregate at £100 a-year each.

This division of England and Wales into 2,000 sanitary districts gives an average area of about thirty miles to each, with an average population of 11,000; whilst a similar division of Ireland into 700 sanitary districts, corresponding to the dispensary districts, would give an average area of fifty square miles, with a population close upon 9,000.

In order to bring this matter before the profession in a convenient form, Dr. Grimshaw and myself presented to the Public Medicine section, at the Annual Meeting of the British Medical Association, August, 1873, "Observations on State Medicine and Public Health in Ireland," which were published in the journal of that Association, September 6th, 1873, and met with the approbation of the most enlightened sanitarians in England. The following extracts from this paper will give an idea of the sanitary requirements of the country, as expressed in those observations:—

"In the matter of the prevalence of zymotic diseases, Ireland is somewhat better off than the sister countries; for, according to a Parliamentary return issued in 1870, the death-rate from zymotic diseases in the three countries, for the five years ending 1869, was—in England, 1 in 190 of the population; in Scotland, 1 in 194; in Ireland, 1 in 300. Now, from this return, it would seem that Ireland requires less sanitary amendment than England or Scotland. This is, to a great extent, attributable to the good system of Poor-law medical relief in Ireland, as compared with the other countries, and to the consequent reduction of the death-rate from efficient curative measures; but especially to the fact, that the Irish population is more rural than the English or Scotch populations, and thus the low death-rate common to rural districts tends to counterbalance the usualy high zymotic death-rate of Irish towns and villages. What points chiefly to the bad sanitary state of the country is the proportion of deaths caused by endemic zymotics, especially fever and diarrhœa; thus, of 87,366 zymotic deaths which are recorded in the return already referred to, nearly a fourth, or 21,895, were caused by fever, and one-eighth, or 10,081, were caused by diarrhœa. It is scarcely necessary, with the late small-pox epidemic fresh in our memories, to refer to the question of the effects of epidemics in Ireland. Small-pox fell so heavily on our Irish towns that, in Dublin, the disease proved more fatal than in Liverpool, and nearly twice as fatal as in London; and in Cork a still higher rate of mortality was reached. Thus the sanitary state of Ireland, as measured by the prevalence of endemic and epidemic disease, is not such as it should be.

"According to the Report on the Status of Disease—Vital Statistics Census, 1871, just published,—it appears that, on the 2nd April, 1871, when the sick in Ireland were numbered 97.5, or close upon 100 persons in every 100,000 of the population, were labouring under some form of zymotic or epidemic disease. One in every 14 of the total sick was affected with zymotic or epidemic disease, and one in every 35 of the total sick was sick from fever; this cannot be considered to be a satisfactory condition for a rural population to be placed in with regard to preventable disease.

"If we now look to the amount of sanitary work really done through Ireland, we shall see that it is insignificant. There is no general sanitary organization through the country, and but few, and these all insufficient, attempts have been made to provide local organization—the imperfect organization of Dublin being the best. The best proof of the miserable attempts which have been made at sanitary work is derived from the insignificant expenditure under this head in every district in Ireland, as is shown by a return recently compiled and published for the Irish Poor-law Medical Officers' Association by Dr. Maunsell. From this return it appears that the amount spent in Ireland on sanitary matters is at about the

rate of one-eighth of a farthing in the pound on the Poor-law valuation. In Dublin, where a larger amount is expended than in any other district, it amounted to but the rate of 3¾d. in the pound, or 2d. per head of the population. In 100 out of 273 sanitary districts in Ireland, not a single penny was spent in the year 1871 under the Sanitary Acts; of these hundred, 72 are urban districts—in other words, 72 out of 120 Irish towns are quite unprovided with any sanitary organization. Of the remaining urban authorities which did make some attempt at sanitary improvement, five spent over £100 under the Sanitary Act. Those were—Dublin, £2,050; Belfast, £427; Newry, £578; Queenstown, £201; Athlone, £230; Kingstown, £173, and Mullingar, £140. Of the other towns, two spent from £50 to £100, ten from £10 to £25 each, and the remainder less than £10 during the year 1871, upon sanitary matters. Of these latter, one spent the munificent sum of 4s. in order to provide sanitary accommodation for over 4,000 people, and another provided for the sanitary wants of 1,600 inhabitants for the economical sum of £1 2s. 5½d. The sanitary work done by the rural authorities seems to have been more general than by their urban brethren. We have shown there is almost a total want of sanitary organization in Irish urban, and certainly there is but very little in Irish rural, districts. The total expenditure on sanitary matters for the whole of Ireland was but £9,756 13s. 4d. for the year 1871. Now how does it happen that sanitary matters are so much neglected in Irish towns, and even more so than in rural districts? The answer is simple: as a rule, these towns are quite too small, both in population and area, to constitute urban sanitary districts, and should therefore be included in the rural district in which each may happen to be situated. Thus, according to Dr. Maunsell's report of the 120 urban districts, all, except Belfast, Cork, Dublin, Limerick, Londonderry, and Waterford, are but small portions of dispensary districts. Of the urban districts, there are only two with populations over 100,000—namely, Dublin and Belfast; one, Cork, with a population of nearly 100,000; five with populations of from 20,000 to 50,000; six between 10,000 and 20,000. Of the remainder—all of which must be looked upon as small towns or villages—there are thirty-one with populations of from 5,000 to 10,000. The rest consist of towns and villages with populations under 5,000, ten of them having less than 2,000 inhabitants. From this statement it appears that there are only about fourteen urban districts with populations over 10,000. In our opinion, it is only the class of towns having a population of above 10,000 inhabitants from which distinct urban districts should be constituted, and for which a special sanitary staff should be employed.

"Having shown how much Ireland is in want of a sanitary organization, we wish next to consider how the country is at present suited for the introduction of such organization. It is now a well recognised rule that the house must be the unit of sanitary work, and that, as the houses of the poor are those over which sanitary supervision is most required, those who have the largest dealings with the inhabitants of these houses must be their immediate supervisors; and, as these supervisors must of necessity have medical qualifications, it is manifest that the dispensary medical officers are the persons best suited for the duty of district health-officers. In the large majority of cases they are as well qualified for the service as the generality of medical men are at present. We now meet with the first, and perhaps the only, serious difficulty with regard to the introduction of a sanitary organization into Ireland; and that is, that, although the dispensary medical officers are naturally the best qualified and most suitable persons for district health-officers, yet their districts are, in many instances, not suitable. In extent of area, the districts are suitable, as the unit areas, for sanitary work, being nearly equal to fifty square miles (or about seven miles square).

"The division of land in Ireland appears to be, for Grand Jury purposes, into townlands, baronies, and counties. Certain medical institutions are supported by Grand Jury grants from the county cess, and are therefore arranged according to these areas. These are county infirmaries, a few hospitals unconnected with unions, and the district lunatic asylums. For Poor-law purposes, the divisions are into dispensary districts, electoral divisions, and unions built up from the electoral divisions. The distribution into electoral divisions on the first introduction of the Poor-law system into Ireland in 1847, and their area and boundaries, were determined by the extent and form of the estates of the various landed proprietors in the country. This, no doubt, was done with a good object, namely, to induce landlords to take a special interest in the welfare of those living on their property. The result, however, has been unfortunate. All these property boundaries have been altered by the operation of the Incumbered and Landed Estates Courts, and the proprietors have each endeavoured to diminish the poor-rate in their own electoral divisions by an abortive attempt at driving the poor out, the result of which is the concentration of the population in small but overcrowded villages, one of which is

found in almost every dispensary district. This evil can only be got rid of by adopting a system of union instead of electoral division rating.

"Owing to the straggling nature of electoral divisions, the dispensary districts which may be said to be identical with these are of such shapes as to be almost unworkable. Some are long, straight strips, twenty five miles long and but a couple of miles broad: others are S shaped, or, in form, fitted into one another like the pieces of a dissected map. Such districts, as existing on a larger scale in England, have recently been demonstrated by Dr. RUMSEY, in the *British Medical Journal* of June 28th, 1873, being the result of the absurd arrangement under the English Public Health Act. This interferes in every way with the working of every branch of the duties of the medical officer. A patient may have to send twenty or thirty miles back and forward for medical advice or medicine, as there are no apothecaries or dispensing druggists in Irish rural districts. The medical man has to travel similar distances to see his patients, thus making it impossible to visit each as frequently as he could wish, and preventing the possibility of attending to two or more serious cases situated widely apart. This arrangement also effectually interferes with the registration of births and deaths, as, although the people travel long distances to obtain medical advice in serious cases, yet they will not merely to register a birth or death—matters of no consequence to them, and of little to the medical officer, who is badly paid for this duty, his fee being but 1s. for each registration. The certificate of registration of death is not required on burial, as in England, and therefore the friends of the deceased can gain nothing by having the death registered.

"This want of equable and properly divided districts also obstructs vaccination to a serious extent. The people will not go the distances necessary to reach the dispensary in an irregularly formed district; they may have to go fifteen miles or so to the dispensary; they cannot go to a dispensary in a neighbouring district, although it may be but half a mile off, as the officer there will not be paid for the vaccination of a person out of his district, and cannot, therefore, be expected to perform the operation. The remuneration is too low to make it worth the vaccinator's while to look up the cases and go to the persons requiring vaccination. The pay is but 1s. per case in Ireland under any circumstances, whereas in England the minimum is 1s. 6d., increasing to 3s. and over, according to distance, with the addition of gratuities. These gratuities in England, in 1871, amounted to within a few pounds of as much as the whole sum spent on vaccination in Ireland.

"Thus, throughout the whole country, an ample re-arrangement of boundaries and squaring of districts is required to make it fit for the reception of a perfect system of preventive and curative medicine. Such alteration of boundaries may be accomplished under the provisions of the Act 35 and 36 Vic., cap 48.

"We now proceed to consider how the present state of things in Ireland may be improved; and we believe an extension of the English Act to that country will not make matters much better than they are at present.

"The English Act has not worked well in England, and, if extended to Ireland, would be a total failure, from the very different circumstances of the populations in the two countries. A great deal of the want of success which has attended the English Act must be attributed to the almost total absence of system in the English Poor-law medical service. The English Act, of necessity, had to deal with the sanitary conditions of many large towns, and hence urban sanitary districts received more than their share of attention from the law-makers. Thus, in England and Wales, 12,000,000, or about one-half the population, reside in large towns, while in Ireland the town populations have to the country populations a proportion of but one to seven. It appears that 223 appointments have been made in England and Wales under the recent Act; of these, 190 were to rural, 25 only to urban, and 8 conjointly to rural and urban districts.* Now, in Ireland, we have but three towns which, in England, would be considered large; that is, having a population of about 100,000 or upwards, and only fourteen towns which, even in Ireland, can be treated as large towns; that is, with a population of over 10,000. Therefore, in Ireland, provisions for rural sanitary districts are much more important than for urban districts. In urban districts, the sanitary authority is the town authority (corporation or town commission); in rural districts, the Poor-law guardians are the sanitary authority. All these authorities are usually included under the generic term 'local authorities.' It is manifest that it would be out of the question for each union in Ireland to appoint a health-officer for the whole union. He must be a local practitioner, or else get a large salary to make him independent of practice. Such a salary could not be paid in each of the 163 Irish unions; and, if a prac-

* The number of appointments has, since the date of this paper, been increased to 1,000, with salaries averaging £100 a-year each.

titioner were employed to go over the whole area, he must either neglect his private practice or his public duties; and, as the former would probably be the more lucrative, the latter would probably suffer. We therefore suggest that each Dispensary Medical Officer should be the health-officer of his own district; thus, each country union would have from four to six Health Officers. We consider that the qualifications should be distinctly defined by Act of Parliament to be those which entitle the holder to be registered under the Medical Acts. There is, it must be admitted, some truth in the statement that medical men, as a rule, are unfit for public sanitary duties, in the highest sense of the phrase, but this is owing to the want of such special service. Once the demand is established, the supply will be provided; and we have no doubt that, not only State Medicine diplomas, such as those now granted to the University of Dublin for specialists of a high class, will be established by all licensing bodies, but that soon a fair knowledge of this science will be demanded of every candidate who wishes to become a qualified medical practitioner. Each of these officers would superintend the health of a district having an average area of fifty square miles, and an average population of 8,000, living in an average of 1,500 houses.* The Dispensary Medical Officer, as registrar of births and deaths, and public vaccinator, must of necessity be conversant with the sanitary conditions of each and every part of the district and its inhabitants. These district health officers should only collect information, and report thereon to their dispensary committees at stated periods—monthly in rural, and weekly in urban districts, or as often as occasion requires, to the medical inspector of the district (an officer whose duties we shall define presently). It should not, in any case, be the duty of the Dispensary Medical Officer, as health officer, to institute legal proceedings against offending parties, as such action would frequently bring him into unpleasant collision with his patrons and employers. When legal proceedings are necessary, they should be taken under the direction of the medical inspector. In urban districts, the Dispensary Medical Officers should still be the immediate district health-officers for making reports on the sanitary state of their various dispensary districts; but, in addition to them, there should be, for each urban district of large size, a chief officer of health, to whom (not to the medical inspector, as in rural districts) the district officers should report; and this chief officer of health should take all such proceedings, legal or otherwise, that might be necessary, and weekly forward a summary of all reports received, and proceedings taken, to the District Inspector, or direct to the Local Government Board and to the nuisance authority of the district. His action should be, to a great extent, but not altogether, independent of the Medical Inspector, and he might, in case of difficulty or doubt, call in the assistance of the Inspector. It is of the utmost importance that all responsibility, after his report has been made, should at once be removed from the Dispensary Officer, as, if not, he would almost immediately get into hot water with his masters, the Committee. For instance, it is but recently that the Inspectors of the Dublin Sanitary Association had to insist on nuisances being removed and houses closed, which houses belonged to a person who was a member of the local authority. Such a case, as matters at present stand, and they must remain for some time at least, would at once bring the Dispensary Medical Officer into collision with his masters. The Urban Health Officer should be well paid, and, in large places, such as Dublin, Belfast, and Cork, should not engage in private practice, but should, if possible, be attached to a public hospital and medical school, in order to keep their medical knowledge *au courant* with that of the day. In towns of less size (of populations under 20,000), and consisting of two or more dispensary districts, the Health Officer might be a private practitioner, but should not be a Dispensary Medical Officer, although it is pretty certain that it is from the Dispensary Medical Officers that the best chief Health Officers would ultimately be obtained; but, on accepting such an office, he should at once vacate his dispensary appointment. We believe that only about a dozen Urban Chief Health Officers would be required in Ireland; in all other cases, the Dispensary Officers, acting through the Medical Inspectors, would serve the necessary purpose. We have mentioned Medical Inspectors; these should be selected and appointed by the Local Government Board on account of special qualifications for the office. Such qualifications should be prescribed by Act of Parliament—namely, knowledge of sanitary science and of the duties of Health Officers. We consider eight such Inspectors sufficient for Ireland, and believe that a less number would not do. These eight Inspectors should correspond with the eight registration districts into which Ireland has been divided by the Registrar-General; each of these districts would contain from twenty to twenty-five unions, which, consolidated, would constitute one chief sanitary district, to be worked under

* A fee of 2d. per head on the population, or 1s. per house, would not appear to be an exorbitant sum to pay for sanitary supervision for an entire year.

a Medical Inspector or Chief Health Officer for the whole, thus obviating the necessity for innumerable Health Officers appointed by each little urban authority, numbering 121 in all, in Ireland.

"It may seem odd to some that we should not recommend counties or combinations of those counties as suitable areas for the inspectors' districts. We have considered this question and find that, unless the boundaries of nearly all the Irish counties were materially altered, such an arrangement could not be carried out. A glance at the map of Ireland will shew how impossible it would be to constitute areas with the present county boundaries. The forms of the counties are quite too irregular to admit any such arrangement, and we consider that it would not be worth while to alter the county boundaries. The unions can, with little alteration, be easily combined into suitable districts. As already stated, the dispensary districts must be squared, and their areas made more uniform than at present.

"We consider that the Public Health Inspector should also be the Medical Poor-law Inspector for the district in which he is situated. His jurisdiction should run parallel with, but not interfere with that of the non-medical inspector. All medical and sanitary matters should be transferred to the public health department of the Local Government Board, and conducted by the medical commissioner (whose office, we trust, will not be abolished) as its head. There are at present ten Poor-law Inspectors—six lay and four medical. The lay inspectors might be increased to eight, who should perform fiscal duties only. The medical inspectors should also be increased to eight, who should have charge of the whole medical service, both preventive and curative. Where local investigations are held under the recent Local Government Act, the two Inspectors should act together as a court of enquiry.

"Our proposed organization would therefore stand thus:—

"1. A Medical Commissioner who should be, as at present, the head of the Public Health Department.

"2. Eight District Medical Inspectors, who should have the charge of the whole medical service, both preventive and curative, each in his own district.

"3. District Health Officers, who should be the Dispensary Medical Officers.

"4. Special Health Officers for towns over 10,000 inhabitants composed of more than one dispensary district.

"The question of the constitution of an Urban district into an Urban sanitary district should be determined by the Local Government Board. How should these appointments be made? For our own part, we should like to see the whole service for the public prevention and cure of disease converted into a civil medical service appointed and paid by Government, with admission by competitive examination, and promoted by selection.

"This, however, cannot be done at once. As the local authorities practically pay the officers, they must have a voice in their appointment, as at present. The Medical Commissioner must, of course, be appointed by the Crown, and he, with his brother commissioners, should appoint the inspectors. The Crown should not meddle in this matter, as it is directly the interest of the commissioners to appoint efficient men, and they will best know how to find them; they would probably always be obtainable from the class of urban health officers. The dispensary medical officers must be appointed as at present, if paid as at present; but, if they become health officers, acting under sanitary authorities, they must, of course, be appointed by the sanitary authority of the district, whether urban or rural. In the rural, the appointment would rest, as at present, with the guardians, but in urban districts the appointment must be made in a totally different manner, which at once raises the question of the constitution of urban districts and their sanitary authorities. Upon this point, we consider that no urban district should be constituted for a town of less population than 10,000; and even in this case, if the town fall within a dispensary district, the dispensary district should be the area and the dispensary medical officer the health officer for that sanitary district; when the whole or parts of two or more dispensary districts are included in a town, then these districts should, in combination, constitute the sanitary district. In reconstructing dispensary districts (which is an absolute necessity), this should be borne in mind with regard to the smaller towns, In the large towns, where there are suburban townships, the sanitary district should include all the townships and adjoining dispensary districts.

"With regard to the constitution of the sanitary authority, we consider that that authority should be a Public Health Committee, composed of members elected by the several co-operating authorities. Thus, in Dublin, we should have two, if not three, unions concerned, together with at least six suburban townships co-operating with the Corporation of the City of Dublin, and possibly with the Dublin Ballast Board, which has charge of the Port of Dublin. The question as to the

constitution of an urban authority, and the area of its jurisdiction, should be determined by the Local Government Board (possibly by provisional order in large towns, and summarily in smaller places.)

"As to the expense of carrying out these proposals, we believe the total annual cost of the whole sanitary organization, as proposed in the foregoing remarks, would amount to about £100,000 a-year, which would represent a tax of about 1d. per acre per annum, or less than 1½d. in the pound on the present Poor-law Valuation, that is about ¾d. in the pound on the real valuation of property in Ireland. The Commissioner at the head of the department should receive from £1,500 to £2,000 a-year; the Medical Inspectors about £1,000; the Dispensary Officers in rural and but sparsely populated districts, from £50 to £75 per annum, and in urban from £75 upwards to £200 or £300 for the smaller, and from £500 to £1,000 for the larger towns. We do not wish to suggest that our scheme is perfect; but no systematic organization has up to the present been proposed, and we believe that, without a thorough, systematic, complete, and properly paid organization to start with, no good result can be expected from further sanitary legislation for Ireland."

I have considered it to be desirable to place this question before you so fully in order that you may perceive to what extent it will be likely to effect the Poor-law Medical service in this country, and also that you may forward any suggestions that may occur to you on the subject at an early opportunity. As I have been asked by a number of Poor-law Medical Officers to summon a committee to discuss the question of a Public Health Bill for Ireland, perhaps it would be convenient for you to attend, if not, any communication you will kindly make to me on the subject will be carefully considered at the Meeting. I shall feel obliged by your communicating with me upon the subject.

The principal questions to which I would ask you to direct your attention and that of the Member of Parliament for your borough or county, are :—

1st. The constitution of the Poor-law Medical Service of Ireland into a State Medical Service, on the basis of the Civil Service.

2nd. The total payment and the chief control of this Service by the State.

3rd. Adequate remuneration for all services rendered to the public by any of the Officers of the Service.

4th. Increase of pay by length of service and promotion to the higher offices by selection.

5th. The handing over of all Civil Public Medical and Sanitary duties to the Officers of this Service.

6th. A certain and substantial scale of retiring allowance in case of retirement from age, infirmity, or loss of health in the Service.

7th. A general re-adjustment of the areas of Dispensary Districts, so as to meet the convenience of the sick poor, the public, and the Medical Officers, which would be greatly facilitated by the substitution of a system of Union for Electoral division rating.

It is of importance that these questions should be discussed at an early period, so that we should be prepared with a statement whenever the matter may be brought forward in Parliament; and the present time affords a good opportunity, as the President of the Local Government Board of Ireland, the Right Hon. Sir Michael Hicks-Beach, is well acquainted with the subject of Sanitary Legislation and its shortcomings in England, and, with the assistance of the other members of the Board, who have had such experience of the Irish Poor-law Medical System since its origin, and have so greatly contributed towards its efficiency by the thoroughness of their elaboration of its details, there is no doubt but that a comprehensive scheme might be brought forward, by which existing laws might be more effectively administered, and further regulations necessary for the prevention of disease and the prolongation of life might be safely enacted, so as to meet both the requirements of the public and the medical profession. In order that we may be enabled to obtain a *locus standi*, in the event of the introduction of such a measure this session, I must impress upon you the importance of your co-operation, and ask you to join the Association, if you have not already done so, in order that we may be provided with the sinews of war when the time for action may arrive.

I am, dear sir,

Yours, very truly,

D. TOLER T. MAUNSELL, *Hon. Sec.*,

Irish Poor-law Medical Officers' Association.

P.S.—The subscription, 5/-, for the year 1874, is now due and payable to Dr. Speedy. P. O. Orders to be made payable to Albert O. Speedy, 28, North Frederick-street, Dublin.